DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 8/27/11

PRINTED: 07/15/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445156	A. BUILDING _____ B. WING _____	07/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL MANOR HEALTH CARE	902 BUCHANAN RD NEW TAZEWELL, TN 37825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint investigation #28210 and #28127 were completed in conjunction with the annual recertification survey at Laurel Manor Health Care on July 11-13, 2011. No deficiencies were cited in relation to the complaints under 42 CFR Part 482.13, Requirements for Long Term Care.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157 D	Physician was notified by a Licensed Nurse of Resident #19's refusal of insulin as ordered by physician, and Physician was notified of residents blood sugar results. Physician modified Resident #19's blood glucose management plan taking the resident's choice into consideration. No negative outcome for resident. Physician and Director of Nursing reviewed all Residents that require blood glucose management plan. Policies for physician notification were reviewed with each licensed nurse by the Director of Nursing with signed acknowledgement of understanding from each nurse. Medical records, medication administration records,and Resident treatment records will be reviewed for compliance of policy regarding physician notification weekly for 8 weeks by the Director of Nursing or designee. Results of medical record, medication administration records, and resident treatment records will be discussed monthly as a component of the facility QI and QA program with Business action plans developed for identified trends. 8-13-2011	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Juanita Honeycutt — TITLE: Administrator — (X6) DATE: 7-28-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to notify the physician of one (#19) resident's refusal of insulin administration; and failed to notify the physician of high blood glucose levels for one (#19) of twenty-six records reviewed. The findings included: Resident #19 was admitted to the facility on October 29, 2009, with diagnoses including Paraplegia and Diabetes Mellitus. Medical record review of the Minimum Data Set (MDS) dated June 12, 2011, revealed patient #19 scored "15" on the Cognitive Patterns Assessment indicating no deficit in the mental assessment. Observation on July 13, 2011, at 9:45 a.m., revealed resident #19 propelling self through the hallway on the south station. Interview at the time of observation revealed, "I do not like my sugar (blood glucose) to drop too low...makes me feel horrible...I refuse it (insulin) a lot or will just take a part of what is ordered...some nurses are good and don't try to make me take it.." Medical record review of the physician recapitulation orders for July 2011, revealed an order dated March 10, 2011, for blood glucose to	F 157		

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F 157	Continued From page 2 be checked four times a day (before each meal and at bedtime); and a sliding scale for regular insulin administration. Medical record review of the Medication Administration Record (MAR) for July 2011, revealed resident #19 refused administration of insulin eight times from July 1-12, 2011. Medical record review revealed the following blood glucose levels and the insulin ordered to be given: July 1 at 7 AM-blood glucose level 167-insulin 4 units ordered; July 2 at 4 PM -blood glucose level 175-insulin 4 units ordered; July 7 at 7 AM-blood glucose level 230-insulin 4 units ordered; July 8 at 7 AM -blood glucose level 227-insulin 4 units ordered; July 9 at 11 AM-blood glucose level 230-insulin 4 units ordered; July 10 at 7 AM -blood glucose level 265-insulin 8 units ordered; July 11 at 7 AM-blood glucose level 267-insulin 8 units ordered; and July 12 at 7 AM -blood glucose level 207-insulin 4 units ordered. Medical record review of the facility policy number N-R-007 titled Refusal of Treatment, reads, "When a resident refuses a medication or treatment procedure, the refusal is to be reported to the attending physician by the Licensed Nurse." Interview with the North Unit Manager of the North Unit in the Director of Nurses office on July 13, 2011, at 10:35 a.m., verified resident #19	F 157		

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F 157	Continued From page 3 refused the administration of insulin, and confirmed the facility failed to notify the physician of the resident's refusal of administration of insulin. Medical record review revealed a physician order dated March 10, 2011, for a blood glucose level above 450 to call the physician. Continued medical record review of the Sliding Scale Medication Administration Record for April 2011, revealed a blood glucose level of 508 at 11 AM on April 13; and a blood glucose level of 518 at 4 PM on April 13, 2011. Medical record review revealed no documentation the physician had been notified of the elevated glucose level. Interview with the North Hall Manager in the Director of Nurses office on July 13, 2011, at 10:35 a.m., confirmed the facility failed to notify the physician of the high glucose levels.	F 157		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, and interview, the facility failed to monitor blood glucose levels as ordered by the physician for one (#18) and failed to follow the sliding scale for two (#4, #12) of twenty-six residents reviewed.	F 281		

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F 281	Continued From page 4 The findings included: Resident #18 was admitted to the facility on February 10, 2007, with diagnosis of Diabetes Mellitus. Medical record review of a physician's order dated March 18, 2011, revealed an order for "BS (blood glucose monitoring) 7 a.m. and 8 p.m..." and sliding scale insulin. Medical record review of the Medication Administration Record (MAR) for April-July 2011, revealed the blood glucose levels were obtained daily at 7:00 a.m., and 4:00 p.m., not at 8:00 p.m. as ordered. Interview with North Hall Unit Manager on July 13, 2011, at 9:05 a.m., in the South Hall Nurse's Station, confirmed the physician's orders for blood glucose monitoring were not followed. Resident #4 was admitted to the facility on February 5, 2011, with diagnoses including Diabetes Mellitus. Medical record review revealed a physician's order dated March 30, 2011, for blood glucose to be checked four times a day and insulin to be administered according to a sliding scale. The sliding scale was listed as the following: "Blood glucose of 151-200 =2 units of Humulin R insulin; Blood glucose of 201-250 =4 units of Humulin R insulin; Blood glucose of 251-300 = 6 units of Humulin R insulin;	F 281 D	Physician and Director of Nursing reviewed the Glucose management plan for resident #18, resident #4, and resident #12. A modified glucose management plan was discussed with each resident and implemented. Physician and Director of Nursing reviewed all Residents that require blood glucose management Plan. Policies for following physician orders were reviewed with each licensed nurse by the Director of Nursing with signed acknowledgement of understanding of policy by each nurse. Medical records, medication administration records, and Resident treatment records will be reviewed for compliance of policy regarding following physician orders weekly for 8 weeks by the Director of Nursing or designee. Results of medical record, medication administration records, and resident treatment records will be discussed monthly as a component of the facility QI and QA program with business action plans developed for identified trends.	8-13-2011

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F 281	Continued From page 5 Blood glucose of 301-400 = 10 units of Humulin R insulin; and Blood glucose greater than 400 give sliding scale insulin, recheck in 1 ½ hours, notify MD (Medical Doctor) if no changes." Medical record review revealed a physician's order dated April, 28, 2010 stating, "Any BS (blood sugar/glucose) less than 60 give 1 mg (miligram) Glucagon (medication to raise the blood sugar level) SQ (subcutaneously), IM (intramuscular), or IV (intravenously), Re-check in 30 minutes, call MD if still less than 60." Medical record of the July 2011 MAR revealed at 7AM on July 6 the blood glucose level was 45 (normal level is 60-100). Review revealed no documentation of Glucagon administration and no documentation of a glucose level recheck at 7:30 a.m., before the next scheduled check. (Blood glucose at 11 AM was 203). Interview in the Director of Nurses' (DON) office with the North Hall Unit Manager on July 12, 2011, at 3:33 p.m., confirmed the facility failed to follow the physician's order for the treatment of low blood sugar. Continued medical record review revealed the glucose level was 418 on July 5, 2011, at 4 PM. Review of the MAR revealed 10 units of insulin was administered and the blood glucose was rechecked and documented to be 397. Interview in the DON's office with the North Hall Unit Manager on July 12, 2011, at 3:33 p.m., verified the physician's order does not specify the amount of insulin to be administered for a	F 281		

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F 281	Continued From page 6 glucose level of greater than 400; and confirmed the facility failed to follow the physician's order for the treatment of high blood sugar. Resident #12 was admitted to the facility on January 5, 2011, with diagnoses including Diabetes Mellitus and End Stage Renal Disease requiring Hemodialysis three times a week. Observation on July 12, 2011, at 7:20 a.m., revealed resident #12 eating a double portion meat and eggs breakfast while in bed. Medical record review revealed a physician's order for blood glucose level to be checked as needed with sliding scale insulin. The sliding scale was listed as the following: "Blood glucose of 151-200 =2 units of Humulin R insulin; Blood glucose of 201-250 =4 units of Humulin R insulin; Blood glucose of 251-300 = 6 units of Humulin R insulin; Blood glucose of 301-400 = 10 units of Humulin R insulin." Observation of the Sliding Scale Medication Administration Record revealed on April 8, 2011, at 11 AM, the blood glucose was 154. Medical record review revealed no documentation of sliding scale insulin administration. Observation of the Sliding Scale Medication Administration Record revealed on May 4, 2011, at 8 PM, the blood glucose was 164. Medical record review revealed no documentation of sliding scale insulin administration.	F 281		

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F 281	Continued From page 7 Observation of the Sliding Scale Medication Administration Record revealed on May 5, 2011, at 8PM, the blood glucose was 181. Medical record review revealed no documentation of sliding scale insulin administration. Observation of the Sliding Scale Medication Administration Record revealed on May 6, 2011, at 8 PM, the blood glucose was 203. Medical record review revealed no documentation of sliding scale insulin administration. Interview in the DON's office with the North Hall Unit Manager on July 12, 2011, at 3:33 p.m., verified the insulin was not administered per the sliding scale; and confirmed the facility failed to follow the physician's orders.	F 281		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide hand and nailcare for one (#7) of twenty-six residents reviewed. The findings included: Resident #7 was admitted to the facility on October 6, 2010, with diagnoses including Advanced Senile Dementia, Psychosis, and	F 312 D	Resident # 7 was provided hand and nail care Residents that are unable to carry out activities of daily living were assessed for hand and nail care by a licensed nurse and those needing nail care were provided services by staff. Policy for ADL care of hands and nails was reviewed with all Nurses and Nurse aides by the Director of Nursing with all signing acknowledgment of understanding. The residents that are unable to carry out activities of daily living will be assessed weekly by a licensed nurse for compliance with ADL care plan. Results of resident assessments will be discussed Monthly as a component of the facility QI and QA program, with Business Action plans developed for any identified issues or trends. 8-13-2011	

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F 312	Continued From page 8 Anxiety. Medical record review of the Minimum Data Set dated June 15, 2011, revealed the resident had impaired short and long term memory, was short tempered, and required total assist with all activities of daily living. Observation on July 11, 2011, at 8:30 a.m., 10:30 a.m., 12:50 p.m., and 3:23 p.m., on July 12, 2011, at 7:45 a.m., 8:45 a.m., 10:00 a.m., and 11:40 a.m., in the resident's room revealed the resident with four fingernails (tip of one finger missing)on the right hand, and all five fingernails on the left hand at least ½ centimeter (cm) past the fingertips. Continued observation revealed all ten of the resident's toenails were approximately ½ cm past the toe tips. Observation and interview on July 12, 2011, at 11:40 a.m., in the resident's room with Certified Nurse Assistant (CNA) #1 and #2 confirmed the resident's fingernails and toenails needed trimming. Continued observation and interview revealed the resident's left hand was in a fist, the resident was encouraged and assisted to open the left hand and an offensive odor came from the hand, CNA #1 and CNA #2 confirmed the inside of the left hand had an offensive odor and needed to be washed. Continued interview revealed the resident was given a shower that morning and due to the resident being combative the CNA's did not trim the fingernails or toenails; or wash the inside of the left hand. Continued interview with CNA #1 and CNA #2 revealed they did not routinely trim the resident's nails or wash the inside of the left hand due to the resident's combativeness.	F 312		

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F 312	Continued From page 9 Observation on July 13, 2011, at 10:35 a.m., in the dining room revealed the resident with the fingernails trimmed, and no odor came from the left hand.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure indwelling urinary catheters were used for medical reasons for two (#7 and #6) of twenty-six residents reviewed. The findings included: Resident #7 was admitted to the facility on October 6, 2010, with diagnoses including Advanced Senile Dementia, Psychosis, and Anxiety. Medical record review of the Minimum Data Set (MDS) dated June 15, 2011, revealed the resident had impaired short and long term		**315 D** Medical Justification for use of indwelling foley Catheter was evaluated for resident #7 and Resident #6 and Medical justification was documented by the physician. Residents with indwelling foley catheters were reviewed For documented medical justification for the use of the indwelling foley catheter. A foley Catheter medical justification assessment was implemented for residents admitted with an indwelling foley catheter. Nurses were Trained by the Director of Nursing to use the new assessment tool for all residents admitted with an indwelling foley catheter or residents that require foley catheter insertion while residing at the facility. Director of Nursing or designee will review the admission record of all residents within 72 hours of admission for compliance of completion of indwelling foley catheter justification assessment. Residents with indwelling foley catheters will be reviewed weekly at the facility Focus Interdisciplinary team meeting. Results of compliance reviews will be discussed weekly As a component of the facility QI and QA program, with Business action plans developed for any identified issue Or trend. 8-13-2011	

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F 315	Continued From page 10 memory, was incontinent of bowel and bladder, and required total assist with all activities of daily living. Medical record review of the physician's orders dated June 16, 2011, revealed resident #7 returned to the facility with an order for "...foley to straight drainage..." with no medical reason given. Observation on July 11, 2011, at 8:30 a.m., 10:30 a.m., 12:50 p.m., and 3:23 p.m., on July 12, 2011, at 7:45 a.m., 8:45 a.m., 10:00 a.m., and 11:40 a.m., in the resident's room, revealed the resident sitting in a reclined Geriatric Chair with an indwelling urinary catheter tubing and drainage bag attached to the chair. Interview on July 12, 2011, at 2:00 p.m., at the south nursing desk with Licensed Practical Nurse (LPN) #3 confirmed the resident returned to the facility on June 16, 2011, with the catheter. Continued interview revealed LPN #3 was unsure why the resident had the catheter and the resident's physician was not contacted and a request made to discontinue the urinary catheter. Interview on July 13, 2011, at 10:25 a.m., at the south nurse's desk with LPN #3 revealed the resident's physician was called that morning and a order was given to discontinue the resident's urinary catheter. Resident #6 was admitted to the facility on March 3, 2011, and readmitted on April 27, 2011, with diagnoses including Amyotrophic Lateral Sclerosis, Hypertension, Gastrostomy, Depressive Disorder, Hyperlipidemia, and	F 315		

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F 315	Continued From page 11 Dysphasia. Medical record review of the MDS dated May 20, 2011, revealed the resident had no cognitive impairment and was totally dependent on staff for care. Medical record review of the admission orders dated March 17, 2011 and the physician orders dated April-July, 2011, revealed the resident had a urinary catheter and no medical justification for a urinary catheter. Medical record review of the Bladder Incontinence Evaluation, undated, revealed the form was not completed to indicate the resident had a urinary catheter or medical justification for the catheter. Observation on July 11, 2011 at 11:30 a.m., in the resident's room, revealed the resident was alert and oriented and had a urinary catheter. Medical record review and interview with the Director of Nursing and the North Hall Manager in the education room on July 12, 2011, at 9:30 a.m., confirmed the resident had a urinary catheter since admission, there was no medical justification for the catheter, and no assessment had been completed to justify the continued use of a urinary catheter.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase	F 318		

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F 318	Continued From page 12 range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide treatment to prevent a decline in range of motion for one (#7) of twenty-six residents reviewed. The findings included: Resident #7 was admitted to the facility on October 6, 2010, with diagnoses including Advanced Senile Dementia, Psychosis, and Anxiety. Medical record review of the physician's order dated May 22, 2011, revealed " ...X-ray L wrist ..." Medical record review of the x-ray results of the left wrist dated May 22, 2011, revealed the resident had Degenerative Arthritic changes, soft tissue swelling and no fractures. Medical record review of the Minimum Data Set dated June 15, 2011, revealed the resident had impaired short and long term memory, required total assist with all activities of daily living and had no problems with range of motion in the upper and lower body. Observation on July 11, 2011, at 8:30 a.m., 10:30 a.m., 12:50 p.m., and 3:23 p.m., on July 12, 2011, at 7:45 a.m., 8:45 a.m., 10:00 a.m., and 11:40 a.m., in the resident's room revealed the resident with the left hand in a fist.	F 318 D	Resident # 7 was evaluated by the Occupational Therapist, and placed on a treatment plan to restore range of motion exercises to hand. Residents with potential to decline in range of motion were screened by therapist. Any resident with potential for decline in range of motion will be placed in a therapy program or a restorative nursing program to prevent decline within 7 days of identification. Therapists were educated by the Therapy Manager regarding the process of screening residents and options for treatment with signed acknowledgement of understanding. Residents admitted with potential for decline in range of motion will be screened within 72 hours of admission and as soon as possible by a therapist when a resident is identified for potential for decline in range of motion. Result of screens will be discussed weekly in a Focus Interdisciplinary Team meeting. Results of medical record audits, resident treatment Records, and screening assessments will be discussed monthly by the Therapy Manager as a component of the facility QI and QA program with Business action plans developed for identified issues or trends. 8-13-2011	

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F 318	Continued From page 13 Observation and interview on July 12, 2011, at 11:40 a.m., in the resident's room with Certified Nurse Assistant (CNA) #1 and #2 confirmed the resident's left hand was in a fist, and the resident's use of the left hand had declined "in the last couple months" Continued observation and interview with CNA #1 and CNA #2 revealed the resident was encouraged and assisted to open the left hand and an offensive odor came from the hand. Interview on July 12, 2011, at 2:00 p.m., at the south nurse's desk with Licensed Practical Nurse (LPN) #3 confirmed the resident had pain in the left wrist on May 22, 2011, and the physician was notified and ordered the x-ray. Interview in the therapy room on July 13, 2011, at 10:45 a.m., with the Therapy Director revealed the Occupational Therapist evaluated the resident's left wrist/hand on May 23, 2011, and the resident was able to have the left hand opened completely. Continued interview revealed the Therapy Director evaluated the resident's left wrist/hand July 12, 2011, in the afternoon and the resident was not able to have the left hand opened completely. Continued interview confirmed no treatment was initiated to prevent the deline in range of motion.	F 318		
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.	F 319		

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F 319	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to provide appropriate treatment for depression for one resident (#6) of twenty-six residents reviewed. The findings included: Resident #6 was admitted to the facility on March 3, 2011, and readmitted on April 27, 2011, with diagnoses including Amyotrophic Lateral Sclerosis, Hypertension, Gastrostomy, Depressive Disorder, Hyperlipidemia and Dysphasia. Medical record review of the Minimum Data Set (MDS) dated March 24, 2011, revealed the resident had no cognitive impairment or mood disorders. Medical record review of the MDS dated May 20, 2011, revealed the resident had no cognitive impairment and was experiencing depression. Medical record review of a nurse's note dated March 30, 2011, revealed, "MD (physician), notified (with), new order for x1 Xanax (1 dose of an anti-anxiety medication) now. Resident very upset...mother passed away...". Medical record review of an Initial Psychiatric Consultation dated April 28, 2011, revealed family conflicts regarding resident's care and "...the resident had another stressor since admit. On 3/30/2011 the resident's mother passed away and this was also very upsetting to the resident.		**F 319 D** Resident #6 was seen by Clinical Psychotherapist on 7-12-2011. No negative outcome for resident. Social Worker reviewed all resident medical records to audit for Compliance. All other residents were in compliance. Mental Health Consultant Group implemented a notification system between their counselors and the facility Social Worker to double Check all referrals for Mental Health services to assure timely Intervention. Mental health consultant notes will be discussed weekly in the facility Focus interdisciplinary team meeting by the Social Services Director for compliance. Mental Health Services will be discussed Monthly as a component of the facility QI and QA program, with business action plans developed for correction of any identified issues of non-compliance. 8-13-2011	

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F 319	Continued From page 15 (Resident) is alert. Can make...needs know(n) accurately...becoming increasingly tearful at times...staff asked to have... medications reviewed for any increase or changes in medication that might help with increasing depression and anxiety...Recommendations...Counselor to evaluate for psychotherapy..." Medical Record review revealed the counselor did not evaluate the resident for psychotherapy until July 12, 2011 (more than two months later). Review of the evaluation revealed the resident was depressed and needed monthly counseling services. Observation and interview with the resident and an adult child on July 12, 2011, at 11:10 a.m., in the resident's room, confirmed there was family conflict regarding the residents care and living arrangements. Interview with the Social Worker on July 12, 2011, at 10:15 a.m., 1:15 p.m., and 4:50 p.m., in the Social Worker's office, and on July 13, 2011, at 7:40 a.m., in the conference room, confirmed counselors had been in the facility 15 times between April and June, 2011; but psychiatric services had failed to communicate the need for counseling services for the resident, which resulted in delay of services for the resident being seen.	F 319		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332		

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F 332	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview, the facility failed to ensure a medication pass of less than five percent by performing four errors in fifty-two opportunities resulting in a seven percent error rate. The findings included: Observation on the South Hall on July 12, 2011, at 8:15 a.m., revealed Licensed Practical Nurse (LPN #3) prepared medications for resident #23. Continued observation revealed LPN #3 gathered Flonase Nasal spray 0.05% spray; 30 ml (milliliters) of an anti-acid and 30 ml of protein liquid orally; and ten pills in a medication cup. The medications in the cup were: Aspirin 325 mg (milligrams), Cetirizine 10 mg, Lisinopril 10 mg, Vitamin B complex, Divalproex 500 mg, Klor-Con 20 millequivalents (x2), Geodon 40 mg, Seroquel 50 mg, and Hydrocodone 7.5 mg/Acetaminophen 325 mg. Continued observation revealed LPN #3 entered the room of resident #23 and administered one spray into the left nare immediately followed by a second spray. Continued observation revealed the LPN administered two sprays in the right nare in the same manner. Medical record review revealed a physician's order dated March 18, 2011, for Flonase Nasal spray 0.05% two sprays per day. Interview with LPN #3 at the South Hall Nurses' station on July 12, 2011, at 9:18 a.m., verified	F 332 D	Physician was notified by the Director of Nursing of Nasal spray error involving resident # 23, Multivitamin error involving resident # 24, and error in Insulin administration that was avoided Involving resident # 4. No negative outcomes were Noted. All resident physician orders were reviewed for similar potential errors none were found. Nurse #3 and Nurse #5 were individually inserviced for noncompliance to facility policies and provided review of medication Pass Policies and Procedures by the Director of Nursing. Medication pass observation by the Director of Nursing was completed with nurse #3 and Nurse #5 with compliance achieved below 2% error rate consistently. Physician orders will be reviewed monthly by Director of nursing or designee in attempt to identify unclear or incomplete orders. Medication Pass observation will be completed by the Director of Nursing or designee with Licensed Nurses 3 times Weekly for 8 weeks then monthly to determine Medication error rate and to maintain compliance of 5% error rate or less consistently. Medication Administration and Medication error rates will be discussed monthly as a Component of the Pharmacy QA presented at the Facility QI and QA monthly meeting attended by the Medical Director, the Director of Nursing, the Administrator, and facility Department managers, with business actions plans developed for correction any issue of noncompliance. 8-13-2011	

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F 332	Continued From page 17 four sprays were administered; and verified two sprays were ordered by the physician. Continued interview and medical record review with LPN #3 revealed a physician's order for Sinemet CR (controlled release) 50/200 to be administered two times daily written on July 6, 2011. Sinemet is an anti-Parkinson's Agent/Dopamine Agonist. Interview with LPN #3 at the South Hall Nurses' Station on July 13, 2011, at 8:05 a.m., verified the Sinemet was not administered (was omitted) on July 12, 2011. Observation on the South Hall on July 13, 2011, at 7:55 a.m., revealed LPN #5 prepared medications for resident #24. Continued observation revealed the LPN obtained a bottle of Multivitamins with Iron from the medication stock room; opened the bottle and poured a pill into the medication cup. Continued observation revealed LPN #5 administered the Multivitamin with Iron to resident #24. Observation revealed the Multivitamin with Iron provided 18 mg of Iron, 100% of the recommended daily allowance. Medical record review revealed a physician's order dated May 27, 2011, for Multivitamin one daily. Interview with LPN #5 on July 13, 2011, at 8:19 a.m., outside resident #24's room, confirmed the Multivitamin with Iron was given in error. Observation on July 13, 2011, at 8:22 a.m.,	F 332		

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F 332	Continued From page 18 revealed LPN #5 prepared medication for administration to resident #4. Continued observation revealed LPN #5 gathered a vial of Levemir (long-acting insulin); wiped the rubber septum with an alcohol swab; and entered the vial with an insulin syringe. Continued observation revealed the LPN pulled back on the plunger slowly; and slowly pushed the plunger up; and then removed the syringe from the vial. Continued observation revealed the LPN capped the syringe and gathered supplies; locked the cart; turned and took a step to the room of resident #4. Continued observation and interview included the question, "Is that the amount of insulin you are going to give?" LPN #5 answered "Yes". Observation of the syringe revealed the syringe contained 25 units. Interview and observation of the syringe with LPN #3 (requested as witness from the other end of the South Hall) in the hall near resident #4's room, on July 13, 2011, at 8:26 a.m., verified the syringe contained 25 units of insulin. Medical record review revealed an order dated July 6, 2011, for Levemir 22 units each morning. Interview in the hall with LPN #5 on July 13, 2011, at 8:27 a.m., confirmed the physician's order was for 22 units of insulin and the syringe contained 25 units of insulin. (Continued observation revealed LPN #5 achieved the prescribed 22 units of insulin in the presence of LPN #3 prior administration.) Interview and medical record review at the South Hall Nurses' station with LPN Unit Manager of the North Hall on July 13, 2011, at 10:12 a.m.,	F 332		

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F 332	Continued From page 19 confirmed the facility failed to ensure a medication administration pass with less than 5 % error rate.	F 332		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview, the facility failed to prevent a significant medication error by failing to initiate the administration of a medication (Sinemet) within seven days of the written order resulting in fourteen missed doses. The findings included: Medical record review revealed resident #23 was admitted to the facility on February 25, 2011, with diagnoses including Femur Fracture, Rehabilitation, Depressive Disorder, and a history of Alcohol Abuse. Observation on the South Hall on July 12, 2011, at 8:05 a.m., revealed Licensed Practical Nurse (LPN #3) prepared medications for resident #23. Continued observation revealed LPN #3 prepared and administered a nasal spray; 30 ml (milliliters) of an anti-acid and 30 ml of protein liquid orally; and ten pills in a medication cup (Aspirin, Cetirizine, Lisinopril, Vitamin B, Divalproex, Klor-Con (x2), Geodon, Seroquel, and Hydrocodone). Continued observation revealed upper arm tremors as resident #23 reached for	F 333 D	Physician notified of 7 day delay in medication treatment for resident #23. Order to start medication was received and initiated on 7-12-011 with no negative outcome noted. All resident physician orders were reviewed by the Director of Nursing and designee for similar potential errors, no others were identified. All Nurses were educated regarding medication policies and procedures by the Director of Nursing. Medication Administration audits will be performed randomly by the Director of Nursing and designated nursing managers 3 times weekly for 8 weeks with results discussed in the weekly Focus Interdisciplinary Team meeting. Medication Administration and Medication error rates will be Discussed monthly by the Director of Nursing as a component of the facility QI and QA program attended by the Medical Director, the facility Administrator, and the facility department managers. 8-13-2011	

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F 333	Continued From page 20 the medication cup from the nurse. Medical record review revealed a physician telephone order (signed by the physician) dated July 6, 2011, and timed 7:40 p.m. Medical record review revealed the order was for Sinemet (an anti-Parkinson's Agent/Dopamine Agonist) CR (controlled release) 50/200 to be administered two times daily. Medical record review of the Medication Administration Record (MAR) for July 2011, revealed no documentation of the Sinemet. Interview with LPN #3 at the South Hall Nurses' Station on July 12, 2011, at 1:55 p.m., verified the Sinemet had not been initiated since the order was written. Interview with LPN #3 at the South Nurses' Station on July 13, 2011, at 1:14 p.m., verified the "Sinemet is still not on the MAR" and confirmed the facility failed to initiate the order written July 6 (seven days ago) resulting in the omission of 14 doses of the medication.	F 333		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 431		

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F 431	Continued From page 21 appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to obtain the witness of a licensed person to waste a narcotic (Hydrocodone) and failed to ensure medications were secure. The findings included: Observation on the South Hall on July 11, 2011, at 1:11 p.m., revealed Licensed Practical Nurse (LPN #2) preparing medications for resident #23. Continued observation revealed the LPN removed one controlled substance bubble pack sheet (Hydrocodone 10		**F 431 D** Nurse # 2 and Nurse #1 were immediately counseled for non-compliance. Policy for wasting of narcotic medication and witnessing ingesting of medication was reviewed with Nurse #2 and Nurse #1 by the Director of Nursing. Policy for wasting of medications and witnessing ingesting of medication were reviewed with all licensed Nurses the week of 7-18-2011 with signed acknowledgement of understanding. Medication Pass observation will be completed by the Director of Nursing or designee 3 times weekly for 8 weeks with Licensed Nurses to include review of policy compliance for wasting narcotic medications and witnessing ingesting of medications. Nurses signed acknowledging understanding. Medication Administration audits and pharmacy consultant report will be reviewed by the Director of Nursing monthly as a component of the facility QI and QA program, attended by the Medical Director, the facility Administrator, and facility Department Managers with Business action Plans developed for any issue of noncompliance or negative trends identified. 8-13-2011	

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F 431	Continued From page 22 milligrams/Acetaminophen 500 milligrams) from the locked drawer. Continued observation revealed as LPN # 2 pushed the pill from the bubble pack attempting to place it in the medicine cup; it dropped to the top of the medication cart. Continued observation revealed the LPN picked up the pill and disposed of it in the sharps box and obtained another Hydrocodone from the bubble pack for administration. Observation revealed the controlled medication was disposed of without the witness of a licensed person. Continued observation revealed LPN # 2 administered the medications to resident #23. Review of the facility policy # IE1 titled Controlled Medication Disposal reads, "When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason...It is destroyed in the presence of two licensed nurses..." Interview with LPN # 2 in the medication room of the South Hall on July 11, 2011, at 2:08 p.m., verified the Hydrocodone was disposed of without the witness of a second licensed person. Observation during the initial tour of the South Hall on July 11, 2011, at 8:48 a.m., revealed a container with approximately twenty-five antacid tablets on the bedside table of an unoccupied room (Room #97). Interview with Licensed Practical Nurse (LPN) #4 confirmed the medication had not been stored in a secure environment. Resident #13 was admitted to the facility on July	F 431		

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F 431	Continued From page 23 6, 2009, with diagnoses including Cerebrovascular Accident with Left Hemiplegia, Diabetes, Osteoarthritis, and Peripheral Neuropathy. Review of the Minimum Data Set (MDS) dated June 24, 2011, revealed the resident scored a 15 on the Brief Interview for Mental Status with 15 being the highest possible score. Observation on July 12, 2011, at 3:30 p.m., revealed resident #13 standing in the doorway to his/her room, holding a small cup with multiple medications (pills) in the cup. Continued observation revealed the resident was talking to Licensed Practical Nurse (LPN) #1 who was standing at the medication cart located across the hall from the room next to where the resident was standing. Continued observation revealed the resident handed the cup of medications to LPN #1, and requested different medications. Interview with LPN #1 on July 12, 2011, at 3:45 p.m., on the South Hall, confirmed he/she had failed to witness the resident ingesting all the medication, and the medication had not been maintained in a secure environment. Interview with LPN #1 on July 13, 2011, at 9:00 a.m., at the South Wing Nurses Station confirmed the resident had two different stool softeners and an anticonvulsant medication in the cup when the resident approached LPN #1 in the hallway on July 12, 2011.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 24 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and interview, the facility failed to maintain infection control and proper hand hygiene during medication pass. The findings included: Observation on July 13, 2011, at 8:27 a.m., revealed LPN #5 prepared medication for administration to resident #6. Continued observation revealed LPN #5 gathered medications including a syringe containing 22 units of Levemir insulin and entered the room of resident #6. Continued observation revealed the resident took the medications orally from the medication cup. (Resident #6 stated, "What about my Aspirin and Vitamin D?" before swallowing the medications.) Continued observation revealed LPN #5, pulled up the sleeve on the left upper arm of resident #6; cleansed an area of the back of the left arm with an alcohol pad; removed the cap from the syringe and administered the insulin subcutaneously. Continued observation revealed the nurse wiped the injection site with an alcohol swab and exited the room (without washing the hands). Continued observation revealed the nurse approached the medication cart; turned several pages in the book of Medication Administration Records; opened a drawer containing bottles of stock medications; picked up several bottles and placed the bottles back in the drawer. Observation revealed LPN #5 picked up a bottle of Aspirin 81 milligrams; removed the cap; and with the index finger reached into the bottle and removed a pill and		**F 441 D** LPN # 5 and RN# 1 were removed from med pass for review of Infection control policies and procedures during medication pass with the Director of Nursing. Both nurses were counseled for noncompliance with Infection control Policy. All Licensed nurses were given a verbal and written review of the policy for infection control practice during medication administration by the Director of Nursing the week of 7-18-2011. Nurses signed acknowledgement of understanding. Medication Pass observation will be completed by the Director of Nursing or designee 3 times weekly with Licensed Nurses with focus on policy compliance for Infection Control practices during medication pass. Infection Control compliance during Medication administration will be reviewed and discussed by the Director of Nursing at the facility monthly QI and QA meeting attended by the Medical Director, the facility Administrator, and facility Department managers with business action plans developed for any issue of noncompliance.	8-13-2011

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F 441	Continued From page 26 placed it in a medication cup. Continued observation revealed the LPN placed the cap back on the bottle and returned the bottle to the medication drawer before walking toward the room of resident #6 with the cup containing the Aspirin. Interview with LPN #5 in the hall before reaching the resident's room, on July 13, 2011, at 8:29 a.m., verified the hands were not washed after administration of the subcutaneous injection; verified the unclean hands were used on the medication cart, multiple bottles of stock medication, and unclean fingers were used to obtain the Aspirin. Review of the facility policy # N-H-003 titled Handwashing and Hand Hygiene, stated, "The following are examples of when hand hygiene is indicated...Before and after performing invasive procedures, such as administering injections..." Interview in the conference room with the Infection Control Nurse on July 13, 2011, at 10:49 a.m., confirmed the nurse failed to follow proper Hand Hygiene. Observation of medication administration on July 13, 2011, at 8:30 a.m., in the one hundred hallway, revealed RN #1 (registered nurse) had prepared medication for resident #25. Continued observation revealed RN #1 had medication (pills) in a medication cup, RN #1 poured the pills into palm of left hand (ungloved) counted pills, and placed in second medication cup. RN #1 stated "resident wouldn't appreciate I had poured medication in hand." Continued observation revealed RN #1 went to resident #25 and	F 441		

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F 441	Continued From page 27 administered medication. Interview with RN #1 on July 13, 2011, at 8:45 a.m., in the hallway, confirmed the RN had not maintained infection control during medication administration when the RN poured medication into the palm of the hand.	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a working emergency call system for one bathroom of forty-nine resident accessible bathrooms in the facility. The findings included: Observation on July 13, 2011, at 8:20 a.m., revealed a resident's emergency call system sounded at the South Hall Nurse's Station. Continued observation of the three corridors on the South Hall revealed no emergency call lights located above the door of the resident rooms were illuminated. Interview with Certified Nurse Assistant #1 and #2 at the South Hall Nurse's Station confirmed "the same thing happened yesterday (July 12, 2011), and they (the staff) had to search every room to find out who needed help. " Continued interview		**F 463 D** The call light in room 205 was repaired with no negative outcome. Call light system on south has been evaluated by an outside contractor and certified as functional. All call lights were tested by Maintenance on 7-13-2011 all were functioning properly. The call light system within the facility is scheduled for Testing monthly and checked randomly for function by The maintenance department. All staff received a review of the emergency call system, and signed acknowledging understanding of function and procedure for reporting problems. All emergency systems will continue to be reviewed and maintained for proper function. The results of systems reviews will be discussed by the facility Maintenance Director monthly as a component of the facility QI and QA program attended by the Medical Director, the facility Administrator, and facility Department Managers. 7-13-2011	

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F 463	Continued From page 28 confirmed the staff determined the light was not functioning for the bathroom in Room 205, of the South Hall. Interview with the Maintenance Supervisor on July 13, 2011, at 8:40 a.m., at the South Hall Nurses Station confirmed the malfunctioning call light had not been reported prior to July 13, 2011.	F 463		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure medical records were complete to include physician's progress notes for three residents (#6, #18, #1, #16) of twenty-six residents reviewed. The findings included: Resident #6 was admitted to the facility on March 3, 2011, and readmitted on April 27, 2011, with	F 514 E	Physician Progress notes were placed on the Medical record of resident #6, #18, #1, and #16. Physician progress notes for residents seen by Physician were picked up from physician's transcription office and placed on the medical records on 7-13-2011. Progress notes are current. Physicians will be notified by Medical Records Clerk that Physician Progress Notes must be in the medical record within 72 hours of completed transcription after each physician visit. Medical records clerk will audit Physician Progress notes in resident's medical records monthly for compliance. A medical records report will be discussed by the Medical records clerk at the monthly QI and QA Meeting attended by the Medical Director, the facility administrator, and facility Department Managers, with business actions developed for correction of any issues of noncompliance.	8-13-2011

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F 514	Continued From page 29 diagnoses including Amyotrophic Lateral Sclerosis, Hypertension, Gastrostomy, Depressive Disorder, Hyperlipemia, and Dysphasia. Medical record review revealed a History and Physical dated March 17, 2011, and no physician's progress notes or documentation of a physician visit since March 30, 2011. Interview with the Director of Nursing on July 13, 2011, at 12:40 p.m., in the business office, confirmed the physician made weekly visits but the facility failed to obtain the physicians progress notes for the medical record. Resident #18 was admitted to the facility on February 10, 2007, with diagnosis of Diabetes type 2. Medical record review revealed no physician's progress notes since March 16, 2011. Interview with the Director of Nursing on July 13, 2011, at 12:40 p.m., in the business office, confirmed the physician made weekly visits but the facility failed to obtain the physician's progress notes for the medical record. Resident #1 was admitted to the facility on March 24, 2009, and readmitted on June 5, 2011, with diagnoses including Multiple Sclerosis, Chronic Pain, Pneumonia, and Pressure Ulcers. Review of the treatment nurse's documentation dated June 5, 2011, revealed the resident was	F 514		

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F 514	Continued From page 30 readmitted with a 4.0 cm (centimeter) x 4.0 cm, unstageable area on the left buttock. Review of the treatment nurse's documentation dated June 27, 2011, revealed the area on the residents left buttock had significantly deteriorated. Review of the facility's documentation from June 5, 2011, to July 11, 2011, revealed no evidence the physician had been notified of the change in the resident's wound on the left buttocks. Interview with the Director of Nurses on July 13, 2011, at 9:20 a.m., in the director's office, confirmed the physician was aware of the wound status, and the facility was "behind" in placing the physician's progress notes on the chart. Resident #16 was admitted to the facility on May 13, 2011, with diagnoses including Esophageal Perforation, Anxiety, and Schizophrenia. Medical record review of the Physician's Progress notes section of the resident's chart revealed no Physician Progress notes. Interview with the Director of Nursing on July 13, 2011, at 12:40 p.m., in the business office, confirmed the physician made weekly visits but the facility failed to obtain the physicians progress notes for the medical record.	F 514		